HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on Indigenous and Northern Affairs

INAN • NUMBER 111 • 1st SESSION • 42nd PARLIAMENT

EVIDENCE

Thursday, May 31, 2018

Chair

The Honourable MaryAnn Mihychuk

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● (1545)

[*English*]

The Chair (Hon. MaryAnn Mihychuk (Kildonan—St. Paul, Lib.)): Welcome, everybody. We are here on a study on long-term care. You're at the indigenous and northern affairs committee of Canada. We're sorry that we're late. We had a vote, which means that we were delayed.

Pursuant to Standing Order 108(2), we are doing a study of long-term care on reserve.

Before we get started, I want to always point out that we're on the unceded territory of the Algonquin people, and that it's an important piece of recognizing the truth and working toward reconciliation.

I understand, Chief Maracle, that you're going to be leading and doing the presentation. Go ahead. You have 10 minutes.

You may need a little bit of extra time, I understand.

Go ahead.

Chief R. Donald Maracle (Chief, Band No. 38, Mohawks of the Bay of Quinte): *Sekoh sewakwekon.* Good afternoon, everybody. *Bonjour.*

Thank you to the chair, vice-chairs, and members of the committee for the invitation to present the work of the tripartite working group on first nations long-term care in Ontario.

My name is Donald Maracle. I'm the chief of the Mohawks of the Bay of Quinte, on Tyendinaga Mohawk Territory in southeastern Ontario near Belleville. We have approximately 10,000 members, of whom more than 2,000 live on the territory. As of 2007, we have the ninth largest membership of all first nations in Canada, the third largest in Ontario.

Long-term care is a long-standing priority issue for first nations across Ontario. In fact, I personally participated in a consultation 25 years ago with the Ontario Advisory Council on Senior Citizens, which released its report, entitled *Denied too long: The needs and concerns of seniors living in first nations communities in Ontario*, in 1993.

The advisory council highlighted at that time the lack of long-term care for first nations seniors and recommended increasing the availability of long-term care for first nations communities. The fact of the matter is that, while the provincial and federal governments have made significant investments in long-term care housing and health services since these recommendations were made, many of the concerns raised by first nations communities remain the same.

Like all Ontarians, first nations individuals and families want their loved ones to be able to live at home as long as possible and, when and if required, want additional supports to stay in their communities close to their loved ones. Currently in Ontario and across Canada, the vast majority of first nations communities do not have long-term care homes or adequate seniors housing options in their own communities.

Many first nations individuals who are no longer able to live at home safely must leave their communities to access appropriate housing and care. For those who previously were forced to leave their communities to attend the residential schools, this can be a re-traumatizing experience. While there are a small number of long-term care homes operated by first nations—four in total in Ontario—that provide culturally safe care in first nations communities, the vast majority of first nations residents do not have access to services in their own language, access to the land, traditional cultural activities, or traditional food.

It is important to note that the issues go beyond a lack of long-term care homes alone, and exist within the context of disproportionately high rates of poverty, chronic disease, and core housing needs in first nations communities.

Also, we know that long-term care may not always be the most appropriate or economical solution, depending on a community's needs. Improving access to services such as home and community care, assisted living, and supportive housing availability can often delay or alleviate the need for long-term care.

In June 2017, Grand Council Chief Patrick Madahbee, who's the chair of our chief's committee on health, other first nations leaders, and I met with senior officials from the Ontario Ministry of Health and Long-Term Care, Indigenous Services Canada, and Canada Mortgage and Housing Corporation. Together we committed to forming a tripartite working group on first nations long-term care. Chiefs and assembly passed a resolution to nominate representatives from each of the provincial-territorial organizations—Nishnawbe Aski Nation, the Union of Ontario Indians, the Association of Iroquois and Allied Indians, the Grand Council Treaty #3—the Independent First Nations Alliance, and the Six Nations to the working group.

As housing and health services are delivered to first nations communities and individuals by a variety of departments across jurisdictions, in fact, that jurisdictional ambiguity is one of the key challenges for first nations. We want to be sure that we have the right government representatives at the table. Additional government departments subsequently joined or attended meetings. Our meetings included Ontario's Ministry of Housing and Ministry of Infrastructure and Infrastructure Canada.

The mandate of the tripartite working group was to examine first nations' access to long-term care and other seniors housing and care options, and to make recommendations to both levels of government on opportunities for improvements to services and programming.

Over the past several months, our tripartite working group on first nations long-term care has met several times and we've shared our knowledge, research, and data to understand the health and housing landscape for first nations in Ontario. Our final report, which I'm sharing with you today, contains extensive data analysis, which reveals serious population health needs for first nations across the province, as well as service gaps. It also identifies key priorities for first nations and makes a series of recommendations for improvement.

● (1550)

I will now summarize these elements for the committee, beginning with first nations social determinants of health. First nations people in Ontario face significantly poorer health outcomes than those of the general population, including shorter life expectancy, a higher prevalence of chronic disease, and mental health and addictions issues that result from ongoing discrimination and a legacy of intergenerational trauma.

First nations individuals and communities in Ontario often face barriers to accessing health care due to fractured jurisdictional service delivery, limited cultural safety services, racial discrimination, and geography, which contribute to poor health outcomes.

For virtually all of the social determinants of health, first nations in Ontario fare disproportionately worse than other Ontarians.

First nations incomes—at household and individual level—are substantially lower than the general population's. On average, the after-tax income of first nations people is 72% of the average income of all Ontario residents, $9,191 less, on average. The prevalence of low income after tax was nearly 70% greater in the provincial indigenous population than in the Ontario population as a whole, as well as in the 65 and older group.

Many communities lack basic infrastructure to ensure a safe drinking water supply. As of January 31, 2018, there were 60 long-term drinking water advisories affecting 28 first nations in Ontario. I think it's now 50. This may severely impact the health services that can be delivered in a community, such as dialysis, that require a safe water supply.

Lack of an adequate supply of safe and affordable housing—meaning the houses meet the minimum health and safety standards and the residents are able to afford the occupancy costs—in many first nations communities has tremendous health impacts and often leads to housing insecurity for families and seniors.

Mould growth in houses is a significant issue in many communities, and there are more house fires on-reserve, with a house fire death rate 10 times greater than that for the rest of Canada. According to CMHC's definition of inadequate and unsuitable housing, 34.6% of housing on first nations reserves is considered inadequate and 14.8% unsuitable.

Based on the social determinants of health, you would expect that first nations health needs would be more acute than the general population's. This is precisely what we found.

The tripartite working group was formulated to access new data produced in partnership with the Chiefs of Ontario and the Institute for Clinical and Evaluative Sciences.

The first nations aging study examined frailty in first nations populations. It found, as we know from our own communities, that first nations adults experience higher rates of frailty and chronic disease at a much younger age than the general population.

Approximately one quarter (26%) of first nations adults aged 45-54 are considered "frail". The sharp rise in frailty happens in much younger age groups in first nations populations compared to the general population. It happens 25 to 30 years earlier in first nations on-reserve.

This has tremendous implications for the need for health services such as long-term care.

I would now ask Graham Mecredy, senior epidemiologist at the Institute for Clinical and Evaluative Sciences, to present some of the key findings of the first nations aging study in more detail.

Mr. Graham Mecredy (Senior Health Analyst, Senior Epidemiologist, Institute for Clinical Evaluative Sciences (ICES), Chiefs of Ontario): Thanks, Don.

I'm just going to go ahead and run through three slides here, with a couple of figures of the results that we found.

We start with some basic demographic information. This information comes from the IRS, which is the Indian registry system. It's basically a census of all registered and status first nations people in Ontario. This shows that as you increase in age, there are fewer people, which is to be expected, but the interesting part of this graph is the proportion of those living on and off reserve. That proportion is increasing as you increase in age. Looking at the 45 to 54 age group, it's around 32%, and that increases all the way up to about 40% in the highest age group.

The next figure here is what Don alluded to earlier. It talks about frailty in first nations people. The information for this comes from a different source. It comes from the regional health survey, which is a representative sample of on-reserve first nations individuals across the province. We looked at a list of 16 different frailty indicators that people were asked on the survey—things like self-perceived health, BMI, and vision loss. There's a list in the appendix of the report if you want to see it in its entirety.

Basically, anyone who had over five of those 16 conditions was considered to be frail. If someone had three to five, they were pretty frail. One or two was not that big an issue, as they were not considered to be frail. The easiest way to look at this figure is to look at that bottom section in each age group, the dark blue bar. That shows that as you increase in age groups, the proportion of people who are frail living in first nations communities is increasing dramatically. It increases all the way up to the age of about 65, where it reaches 50%.

That is a huge number. To compare it to the general Ontario population, we pulled in data from the CCHS, which is the Canadian community health survey, represented by those red squares on the last two bars there. We didn't have information for all the age ranges, just the older people. Looking again at the 65-year-old age group, only 16% of the general Ontario population in that age group is considered to be frail, compared to 50%, as I stated, on first nations reserves. Obviously that's a huge discrepancy.

As Don mentioned, people living on first nations reserves are becoming frail much earlier than the general population. If you look at the 16% and compare it to the comparable number in first nations, you have to go all the way back to the age of 35. It's a 25- or 30-year difference that we're seeing in the development of that frailty, so it's a big difference.

The last slide here is looking at the percentages of people who have two or more chronic conditions. This comes, again, from the IRS. We have a list of 18 different chronic conditions. Again, that list of 18 is in the appendix of the report, so you can look at that. It includes things like asthma, diabetes, and cancer—serious diseases. We looked among the first nations population, both on and off reserve, at how many people had at least two or more of those conditions across the age groups.

As you can see, that's increasing with age, as you would expect. One interesting thing, looking at the difference between off-reserve and on-reserve populations, is that it actually appears that the off-reserve have a higher rate of multiple chronic conditions. That increases with age, and you can see the biggest discrepancy in the 75-plus group.

We can't say for sure why that's the case. It could be that people who live off reserve have more frequent interactions with the health care system. The way this data is captured is by people going to the doctor, or going to the hospital or the ED. In order to show up in this data, they have to have access to those services. People who live off reserve are likely closer to those services and can access them more easily, and hence show up more in our data. It's also possible that people who have multiple chronic conditions are more likely to move off reserve to be closer to those services. Again, they would show up disproportionately more in the data because of that.

Aside from that, the main take-away from this is the huge number of people living with multiple chronic conditions. Once you get up to the highest age group, 70% to 80% of people have at least two of these serious conditions. These are people who really require a lot of care.

That's all for me, and I'll send it back to Don to finish the presentation.

● (1555)

Chief R. Donald Maracle: Thank you, Graham, for that presentation.

The fact that frailty occurs at a much younger age group in first nations populations compared to the general population points to the need for intensive supports such as home care, assisted living, and long-term care earlier and more often.

As of November 2017, there were 628 long-term care homes in Ontario with 78,943 licensed beds. Of these, only four long-term care homes are located in first nations communities, with a combined capacity of 223 licensed beds, representing less than 1% of long-term care beds in the province. As a matter of fact, it's 0.28.

With regard to health and housing services across the continuum of care, while our working group focused on the need and availability of long-term care for first nations communities and individuals, we also know that long-term care sits alongside continuing care supports that are available. Like all Ontarians, first nations seniors want to live at home as long as they possibly can. Investments in home and community care are available, and availability of congregate living options such as elders homes that provide assisted living or supportive housing may allow more individuals to stay in their homes or community for longer periods.

While retirement homes are an option and often a potential alternative to long-term care for many Ontarians, high poverty rates in first nations communities and the lack of culturally safe and appropriate retirement homes in first nations communities eliminate this private pay option for many first nations seniors.

I also want to mention that first nations communities often have difficulty securing capital financing for health and housing facilities. Even if they have access to operating funding, access to capital funding is complex and jurisdictionally jumbled.

Based on the need and gaps in services, the first nations tripartite working group has identified a number of key priorities and made recommendations to the Ontario and federal governments. The priorities for first nations are improved access to services, improved capital planning and financing, strengthened community decision-making, and improved data collection. In accordance with those priorities, we have the following recommendations.

There should be new long-term care home beds specifically set aside for first nations.

The federal and provincial governments should make new investments across the housing continuum that make the most sense based on community need. Investments should identify and account for additional cost considerations and potential solutions for operational facilities in first nations.

Ontario should examine expanding its existing capital planning grant program to help first nations communities determine what capital investments are required to best meet the health needs of their population.

Canada and Ontario, in partnership with communities, should explore opportunities for innovative and alternative funding arrangements for seniors housing, infrastructure, and capital investments across the continuum, based on the needs of the individual communities, whether that be for long-term care, assisted living, or supportive housing.

Canada and Ontario, in partnership with first nations communities, should establish a mechanism for facilitating the federal-provincial first nations capital planning process. The process should enable a one-window approach for first nations to access the resources they need as opposed to working separately with jurisdictions or individual programs.

Canada and Ontario, in partnership with first nations communities, should improve data collection on first nations seniors' health and access to services in order to fully understand the need and to inform policy-making.

Ontario should work with the long-term care homes sector, human resources sector, and first nations communities to improve culturally appropriate and safe training and to address staffing challenges around delivering services to first nations.

In conclusion, I want to emphasize the pressing need in first nations communities for improved access to housing and health services across the continuum of care. The report we have shared with you today makes the need clear and makes concrete recommendations, which are opportunities to improve the lives of first nations individuals across the province.

There was a news release that the Ontario government has made an investment in additional long-term care beds, 30,000 over 10 years. Five thousand are being allocated now, and 500 of those have already been allocated to first nations communities. The Mohawks of the Bay of Quinte have received 128. There's an indigenous group in Toronto that will receive 128. The rest are being divided up between seven different first nations, but with each tranche of funding, first nations will be a priority because of the long-standing neglect.

● (1600)

The Chair: Thank you.

Questioning opens with MP Mike Bossio.

Mr. Mike Bossio (Hastings—Lennox and Addington, Lib.): Thank you so much, Chief Maracle and Grand Chief Abram, for being here today. We really appreciate this testimony.

These are exactly the kind of data points and information we need, which will greatly help to inform this report and indigenous services moving forward on the need for long-term care.

Chief, when Minister Philpott, you, I, and other representatives of the Mohawks of the Bay of Quinte met this past winter, we discussed long-term care. Facilities was a component of our conversation, along with many others, but it was a central component of that.

For the purpose of the committee and this report, can you please outline the unique challenges and considerations our study should include when looking at long-term care facilities in first nations communities?

● (1605)

Chief R. Donald Maracle: I don't understand your question, Mike.

Mr. Mike Bossio: We know there are a lot of long-term care needs that exist within society, but what are some of the unique challenges that you see within your own community around those needs and the delivery and fulfillment of those needs?

Chief R. Donald Maracle: I handed out some information. On the back page, you'll see a report that's addressed to the regional chief, Isadore Day. It's on Canada's letterhead.

In the Ontario region, there's a unique situation regarding capital. If you turn to the third page, you will see that Ontario has 22% of the indigenous population living on reserves, yet they only received 14.5% of the overall funding. Oftentimes, because of the larger populations on reserves in Ontario and the chronic underfunding of INAC programs, a lot of the capital money that's available gets diverted into O and M expenditures, which makes the capital budget to build new structures very limited.

There have to be measures taken by the Government of Canada to correct this situation that affects the Ontario region. There have been discussions with the associate regional director general, Anne Scotton, and with the headquarters staff. The minister, Jane Philpott, is aware of it. We're just waiting for some corrective action to be taken to address this situation that has plagued Ontario for decades with this chronic, unfair funding allocation to the indigenous communities in Ontario.

Mr. Mike Bossio: What I wanted to allude to, as well, is that the Mohawks of the Bay of Quinte itself it is quite representative of the overall need that exists for long-term care. Maybe what you could do is give us a snapshot of the need for the Mohawks of the Bay of Quinte and how that is reflective of the overall need for indigenous communities.

Chief R. Donald Maracle: I'd like to turn you to another page that I handed out. There's a letter there from our nurse, Gloria George, and she estimates that 37 members.... They have currently 60 members who receive home and community care, so that would represent about 60 households. There are more than 1,200 households in our community. In addition to that, we have about 2,200 of the 10,000 members who live on the reserve. Within the periphery of the reserve, there are about 3,000 members who live within a short commuting distance of the reserve, and if the services are available in the community, they expect to receive those services because they're members of the band.

Actually, the federal government encourages us to treat all of our members equally. They may have grown up on the reserve and had to move off the reserve because of the lack of housing or to get a job, but when they retire a lot of them do come home, and so there's always a lot of pressure to find housing and long-term care. As you can see in the report, there are a number of people who are on a waiting list for housing at the elders lodge. Many people are frail and can't find affordable housing because of limited incomes. There's also a shortage in the municipalities of affordable housing around the Mohawk reserve, and just about every reserve in Ontario. I know the national government has recognized that there has to be help given to the municipalities to deal with the issue of affordable housing across the country.

Mr. Mike Bossio: I see this list you have. A total of 66 people are on the waiting list right now.

Chief R. Donald Maracle: That's just for housing, but of those, probably a lot of those would need long-term care.

Mr. Mike Bossio: Exactly, and that's what I was going to get at.

Mr. Bouchard.

Mr. Bernard Bouchard (Associate, Assured Consulting, Mohawks of the Bay of Quinte): I was going to mention that in the area of the South East LHIN, there are 5,210 people waiting for long-term care. In Ontario, we know that over the last 14 years we haven't seen a decrease at all in the waiting list. It's actually grown. While the government has announced new beds, and that's welcome news for everyone, there are still over 3,200 people who are eligible for long-term care and can't find a bed to go to. For first nations seniors, many of them can't afford the preferred venue, which is semi-private or private. Often what happens is if you can afford a private room, you can get into the facility much quicker. For first nations seniors living on reserve, their income is so low they're the ones who end up being stuck in the hospital or living at home at risk. We see that the system is not really addressing those issues, and that's why we hear every day about the bad things that are happening in long-term care as well as the hospitals and emergency wards being jammed. For first nations seniors, they don't have the income. They can't access the publicly funded system for private and semi-private rooms so they have to wait for what they call "basic accommodation". Seventy per cent of all the seniors, of the 30,000 in Ontario, can only afford basic accommodation. That's one of the problems.

● (1610)

Mr. Mike Bossio: Would you say a big part of it, as well, is that they could be overshadowed because of the massive demographic bulge that's happening with our aging society within Canada? That's the reverse of what's happening within indigenous communities. There are so many more younger individuals. We're having an exponential growth of youth within indigenous communities, but it's the absolute opposite in—

Mr. Bernard Bouchard: When the Province of Ontario brought in 20,000 beds in 1998, they based it on the formula of people aged 75-plus. At that time, when we looked at the first nations groups in 2006, we saw that the average age was about 10 years younger. What this report demonstrates is that it's even younger than that. We could even look at 55 as being a group that could need long-term care, but you're right; we normally think of long-term care being for somebody 75 and over.

The Chair: The questioning now goes to MP Arnold Viersen.

Mr. Arnold Viersen (Peace River—Westlock, CPC): Thank you to our guests for being here today.

Do you want to finish that thought?

Mr. Bernard Bouchard: No, I'm fine.

Mr. Arnold Viersen: I'm not sure what the real thrust of this is. We didn't come to this study because we saw a major problem; we just wanted to understand it.

Particularly where I'm from in northern Alberta, there isn't really this on-reserve, off-reserve issue. The nearest town ends up being where you end up living in a long-term care facility.

What's interesting is that, reserve or non-reserve, folks are just frustrated about the fact that they have to leave their community and go 100 kilometres down the road to live in a long-term care facility.

I was wondering, from your perspective, where you're at. Is that an issue, as well?

Chief R. Donald Maracle: On the issue of the 78,000 licensed long-term care beds in Ontario, 50% of them have to be redeveloped, or they will lose their licence. If they lose their licence, it's going to make the shortage of beds all the more chronic.

In addition to that, 50% of those beds are for basic rate. If first nations don't have other pensions, other than the old age pension and the guaranteed income supplement, they don't qualify. They don't have enough income to be able to afford to go there. Then, coupled with the alarming increase and the waiting lists, the way it's growing for long-term care....

In the South East LHIN there is a 99.2% occupancy rate, which means that people have to wait until someone dies to free up a bed. The South East LHIN has the most severe chronic waiting list of all the homes, but all of the homes in Ontario have chronic long waiting lists, sometimes up to two years. Both the Canadian government and the Province of Ontario are supposed to be committed to looking after the well-being of the citizens of this country. There is a responsibility on both governments to address this need, which cries out for some immediate attention.

When the Province of Ontario looked at it, they recognized that there was long-standing neglect of first nations investment in long-term care or housing options. That's why the whole file is so dismal.

We are here today to ask the federal government for some capital investments in housing and long-term care and to partner with the Province of Ontario and the first nations communities to address this.

Mr. Bernard Bouchard: I'd like to address your point.

Normally for long-term care, we think of about an hour's radius as being acceptable, but in first nations, if you look at the facilities, there are only four that exist. You might have to go seven hours away, and so the chances of your having interaction with your family are very minimal. It's a lot different than going to Smiths Falls to go into a long-term care facility. I'm working with the Moose Cree First Nation, and it's 1,200 miles. If your senior leaves that community, you're not going to be visiting.

In Ontario, because there's such a lack of long-term care for first nations, they've had to travel all over the place. When the person does move, if it's an older couple, for example, and the husband can't drive, he's not visiting anymore. There are a lot more complications. If you're in an urban setting, that's one thing, but for most first nations, they're looking at being spread out quite a bit.

I don't think the same argument works in that case. That's why we need to support our first nations facilities.

● (1615)

Mr. Arnold Viersen: One of the issues we run across all the time —where I'm from anyway—is that we can build the facility, but getting people to work in it is a whole other story. Have you had any experience in that field?

I'm worried a little bit. Talking about licensed facilities, sometimes what the government does is just lower licensing requirements, and then we get more facilities.

Chief R. Donald Maracle: The Mohawks of the Bay of Quinte have an excellent track record with the First Nations Technical Institute, partnering with colleges and universities to provide training programs so people get the appropriate job qualifications. We would use that model there. There's plenty of money for employment and training for the skills that are definitely needed everywhere in Ontario. There will be plenty of opportunity to get jobs in those fields.

Grand Chief Joel Abram (Grand Chief, Association of Iroquois and Allied Indians): *Shekoli swakweku*, everybody. I'm from the Oneida Nation of the Thames. I was the elected chief from 2008 to 2014. During that time we built a long-term care facility. That was the first one in Ontario in over 25 years, since Akwesasne was awarded some bids. I can speak to some of the difficulties we had in building the facility. At the end of the day all I can say is thank God for the recession in 2008 and some stimulus dollars. First nations are pretty much in a constant recession/depression mode. We were able to get some money out of FedDev, but until that point no place in government would support that. Even INAC said they didn't have any dollars specifically for long-term care facilities. Their priority is on other areas. I don't know about drinking water, considering the situation, but there's just not enough capital.

As for employment and training, we have about 6,000 members, about 2,400 on reserve. We started the training around the same time as the construction was going on. We had start-up programs for PSWs utilizing our employment and training dollars, and also encouraging people to go into RPN and the health programs, those sorts of things. Right now we have around 70 full- and part-time positions through PSWs. We have RPNs, administration, maintenance, the whole gamut. Maybe 60% to 70% are first nations employees. They're not all from Oneida. Some are from neighbouring first nations, some are non-first nations. Our residents are also Oneida and also from local first nations in the southwest region and from the general population as well. We have a combination.

You have to take some initiatives and do some things early on in the staffing process to make sure you build up your human resources to do that. There were a lot of roadblocks.

The Chair: Thank you.

Questioning now moves to MP Rachel Blaney. You have seven minutes

Ms. Rachel Blaney (North Island—Powell River, NDP): Thank you all for being here with us today.

Chief Maracle, could you tell us a little about how your community disburses the federal funding for long-term care? Is there provincial funding as well? Have you had any trouble reconciling the funding?

Chief R. Donald Maracle: It's a 128-bed licence. The province will provide a per bed per capita subsidy of $17.55 per day. It could go up to as high as $18. That would generate about $12 million from the Government of Ontario. The long-term care facility will cost $28.2 million to build, so we're looking for about $15 million.

Ms. Rachel Blaney: Okay, thank you.

Chief R. Donald Maracle: The problem with Indian Affairs is how they define housing. To me, a house is a roof over your head, a place where you eat and sleep. Whether it's a long-term care facility or a bungalow or an apartment, it's still a shelter. The long-term care part is the services provided: nursing care, PSW, meal preparation, bathing. It could be a combination of them, and a different view of what housing is, then I think maybe some money could come from housing, from Indian Affairs, to build the long-term care facility, because people live there.

Ms. Rachel Blaney: I represent a very rural riding, with over 20 indigenous communities. One of the challenges is they're very remote and very small; they're trying to figure out where they're going to send their elders, who are very unhappy.

I think the other part that's so important about this is if we have any dementia in our communities, they often lose their English in some cases, and so they're going somewhere where they don't get the support.

You said you've seen an increase in funding, but the issues are still the same. Can you talk to us about why?

● (1620)

Chief R. Donald Maracle: There's an increase in home support funding, which means the personal support workers and the nurses go to the home and provide care, but a chronic number of people can't find affordable housing, and they are seniors who are vulnerable, who are at risk. Often when their health deteriorates to the point where there are chronic falls or they start to lose their eyesight or they get gangrene and they have to have amputations or the spouse dies, with a lower income, they can't afford the occupancy cost, plus they have a multitude of health issues and frailty combined, so they can't live on their own. Then when you try to find a place in a long-term care facility, you might wait two years. Or if there's Alzheimer's disease, they're at risk of wandering and drowning and all this sort of thing because there's no one to stay with them. The home care does not provide 24-hour care. The maximum they get is four hours a day.

Ms. Rachel Blaney: Yes, which is a huge—

Chief R. Donald Maracle: When people progress and need care beyond that level, the only alternative is a long-term care facility.

Ms. Rachel Blaney: Then you have the challenge of seeing if you can find one that will be able to take them.

Chief R. Donald Maracle: There aren't any. Really, our community would be out of luck. There's no place. The people who are the most frail and most vulnerable have nowhere to go. These are the people who built the roads. They built the hospitals. They've been employed in every occupation. The only thing that this country can say to them when they are the most frail and in the most need of help is that there's no place for them to go.

Ms. Rachel Blaney: We just finished a report on a national seniors strategy. We heard again and again that indigenous communities are one of the most vulnerable senior and aging communities and that this needed to be looked at. One of the things that came up in that report was the lack of data that's collected.

Could you talk to me a little bit about what your community is doing? Do you see the data collection that is needed to measure and look at the issues that are arising?

Chief R. Donald Maracle: When people apply to go into a long-term-care home, if they could say whether they have access to non-insured health benefits, that would prove that they are a status Indian. But there's no data collected like that in any of the 14 men's.... It's based on what the community knows. We have almost 8,000 people living off-reserve. Some of them are 3,000.... Nobody knows what their health is until they come wanting a place. We get calls quite often at the office to help them find someplace for their loved one to be, and there isn't any.

Ms. Rachel Blaney: You talked about being jurisdictionally jumbled. Can you just tell us a little bit of what you mean by that?

Chief R. Donald Maracle: One example is that FedDev should exist to create jobs, long-term jobs. That should be the ultimate goal of the FedDev. Yet they will say they might be able to buy some of the equipment for that place but that would be about the extent of it. With the CORP application, the criteria's still a little bit different. You might get $1 million, or you might get $3 million.

Through Trenval, you might get $250,000. There are various pots of money here and there. If it was coordinated, it would actually help the first nations do better planning and get the projects off the ground a lot faster than if they have to shop around for money.

The federal government needs to have a coordinated approach for essential services, like health care and long-term care. If they created a partnership with the province.... I don't say they should give all the money to the province and let them decide where it's going to go. The federal government needs to have some deliverables attached to the money they hand over to the provinces. The need right now is for capital. The biggest issue in Ontario is capital for projects—for housing, roads, water, long-term care.

Ms. Rachel Blaney: Absolutely.

One of the things you also talked about was the challenges of folks on- and off-reserve. If they live close to the community, they're coming to try to access services on reserve. Of course, they don't necessarily fit in the formula. I'm wondering if you could talk a little bit about those challenges and how you've been creative in addressing them.

Chief R. Donald Maracle: A lot of that is federally imposed. It's not imposed by the first nations. Some of their programs and services are designed for people who live on the reserve. The waiting list is usually made up of people who don't live on the reserve but want to live on the reserve. I gave you a list of the housing criteria to show the number of people who are pounding on our door wanting to live on the reserve. We have to acquire some capital from Canada to correct these issues.

● (1625)

Ms. Rachel Blaney: I'm wondering if you have any insight as to why people who are close to the reserve but living off reserve don't feel comfortable accessing services in the other communities.

Chief R. Donald Maracle: They are not available, for one thing. There's a shortage of affordable housing in nearly every municipality. Oftentimes they're coming to the reserve to see if there's affordable housing only to find that there's a long waiting list. It's really that there's no place for them to turn.

The other thing is that people want to come home. They grew up there. They have family that live there. They want to come home. They've retired. They've worked. Not only were some of these people residential school survivors; a lot of them were veterans who took up arms in the Second World War and other wars as well as serving in peacekeeping times. Now that they are frail, the only answer we have is that there's nothing for them.

The Chair: Thank you.

We're going to conclude the round of questioning with MP Gary Anandasangaree.

Mr. Gary Anandasangaree (Scarborough—Rouge Park, Lib.): Madam Chair, I'm going to yield my time to MP Bossio.

Mr. Mike Bossio: Thank you, my great colleague Mr. Anandasangaree.

Chief, once again, I'd like to go to the reality of the situation that exists within the Mohawks of the Bay of Quinte. We talked a bit about epidemiological data that exists, but it only exists through the Canadian community health survey. There are no data points that give a clear picture of the true need that exists within indigenous communities.

The Mohawks of the Bay of Quinte are a very sophisticated indigenous community, from a governance and administrative standpoint, and you have a far better handle on what is happening within your community than most would. It might be useful to look at your own community and the data points you think would be beneficial to you and then compare them to the needs that exist in other communities that aren't as well managed as yours.

Chief R. Donald Maracle: In terms of data, a lot of our band members have graduated from nursing school. They are licensed nurses, RPNs, and RNAs, and all that. As one of the data points, there's a report there from the nurse who actually visits the people who receive care. The people also have relatives; and we know, from talking with the families, what the needs of their families are. There is no formal way of collecting data right now, and that's what there needs to be, some formal way of collecting data.

Mr. Mike Bossio: You're in charge of a—

Chief R. Donald Maracle: In terms of the non-insured health benefits program administered by Canada, they know the types of medications people are on and what kinds of health issues are out there. They would have data in terms of the health profile of first nations people by reserve, by age group.

I think in the South East LHINs there are 5,000 people on a waiting list. Some of them are chronic placements with no place to go. We know that 3,000 of our members live within close commuting distance to the reserve because of the lack of housing, so I would expect that a significant number of those people who are on the waiting list are our members.

Mr. Mike Bossio: You don't actually have that data, do you?

Chief R. Donald Maracle: We don't have it. There is nobody who collects that data by band number.

Mr. Mike Bossio: In a perfect world, what data points would you like to see? What data points do you think would truly reflect the need that exists for long-term care?

Chief R. Donald Maracle: I think what we need to understand, Mike, is that when you get a licence from the Ministry of Health for long-term care, the beds have to be made available to people in Ontario who need them because they're subsidized publicly. We can prioritize our own members and other first nations first, but if there are beds available, they have to make them available to anybody who needs them because it's publicly funded. That's how all of the beds on first nations reserves.... With Joel's, they have a number of non-natives who live in the Oneida long-term care facility, and it's the same with the other ones. Ours would be no different.

Mr. Mike Bossio: Mr. Bouchard.

Mr. Bernard Bouchard: I was just going to say that I think, from this report, that we can lower the age group now. We can start looking at that kind of data and see how many people are 55 and over who may require this. When the Province of Ontario made their assessment for 20,000 beds, they chose that 75-plus number. Now we're just starting to understand that we have to go lower.

The question is, what is the number we should be looking at to gather information? I think 55 years is a reasonable number, so it wouldn't be that difficult to accumulate that information.

The important point here, though, is that a lot of the first nations are invisible. They're in the hospitals. They're living at home, at risk. Maybe the family is taking care of them, but we don't know what's going on until there is a crisis. I think it's quite frankly under-reported. We would probably need more beds than we are asking for.

● (1630)

Mr. Mike Bossio: I guess that's what I'm trying to get at, because you have on-reserve, off-reserve people in homes, and families living together in homes where the families are taking care of their elders. Is it almost a case where the province assigned that number, but it was a number they took out of the air and said that sounded about right?

Mr. Bernard Bouchard: If we look at the last 14 years, we see that it shows that the waiting list has not diminished. With all the good work that's done in home care, all the good work that's done with the LHIN, and all the the things that keep people in their own homes, we can see that over 14 years it has not reduced significantly the number of people who are waiting.

I operate a long-term care facility and I have a two-year waiting list near Ottawa. People come in and they can't get in. I think with first nations they're even more invisible, and they have less money, so when those rooms do become available, those private and semi-private rooms—and that's 60% of the licence—they won't have access to those beds.

Mr. Mike Bossio: Finally, Mr. Mecredy, I know you're the epidemiologist. In an ideal world, what kinds of data points would you like to see that you would feel would be giving real data that is truly representative of the need?

Mr. Graham Mecredy: I think we're starting to get at it a bit with what we showed, that the aging population is more frail and more likely to have chronic conditions. That starts to get at the need.

Really, though, we don't have data on the number of people who would be applying if those spots were available, and what the wait-list would be looking like. We don't really have access to that sort of data, so I think improvements in that area would go a long way.

Chief R. Donald Maracle: Mike, a few years ago we built a 25-unit apartment building for seniors. Everybody said, "Who will live there?" There's a waiting list of 11 on that, with political lobbying of the council to put somebody out so they can live there.

The other point I wanted to make was that timing is critical in this proposal because Ontario has offered a 128-bed licence to our community. There certainly is a need in the South East LHINs. We know 3,000 of our members live in that area, and 2,200 on the reserve.

We have to get on with planning and getting it designed and built by 2022 to keep the provincial financial commitment there. Right now we need to go ahead with the planning of it and to realize...on the $12 million from the province.

Mr. Mike Bossio: What is the barrier that you see to being able to fulfill this project at the end of the day?

Chief R. Donald Maracle: Capital funding from the federal government.

Mr. Mike Bossio: How much capital funding would that require?

Chief R. Donald Maracle: Fifteen million dollars.

Mr. Mike Bossio: Thank you.

The Chair: That's a good way to wrap up.

Thank you very much for coming out to our standing committee. We appreciate it. Your report was very interesting, and with a lot of statistics. That's very helpful. Thank you very much. *Merci beaucoup*. *Meegwetch*.

We'll suspend for a couple of minutes, and we have another panel that's coming forward.

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——————————— (Pause) ———————————

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● (1635)

The Chair: Welcome to our committee. We're looking at long-term care. Thank you for coming forward and presenting and taking the day to come to Ottawa.

We're going to start with Grand Chief Abram Benedict. You can go ahead. You have approximately 10 minutes. After that, we'll do a round of questioning from the MPs.

Grand Chief Abram Benedict (Grand Chief, Mohawk Government, Mohawk Council of Akwesasne): Good afternoon. *Sekoh*. I bring greetings on behalf of the Mohawk Council of Akwasasne and the community of Akwasasne.

I'm Grand Chief Abram Benedict. I'm joined today by Keith Leclaire, our Director of Health.

Today we're going to describe to you our health services and how we have identified ways to enhance service coordination for the delivery of services to our community. Using culture as a foundation, we employ a strength-based community approach, combining traditional and western-based health options as an integrated health system. For this reason, we are a modern first nation community offering health services based on promoting Akwasasne's cultural strength.

Our community—the map is up here for you to see—is about an hour south of here, on the international border between Canada, the United States. We're a jurisdictionally unique community and an international border community, with half of our community residing in Canada in the provinces of Quebec and Ontario, and the other half in the United States, in upstate New York. This map lays that out a bit. The islands on the northern side, which are grey, and the mainland, are the jurisdiction of the Mohawk Council. The blue, with the red and the blue lines, is the New York state component.

The Mohawk Council is the governing body of the Canadian portion of Akwasasne. My membership is approximately 12,500. The Mohawk Council, as an organization, has eight departments, and about 800 full-time employees—upwards of 1,000 between part-time and full-time—delivering about $100 million in services, in partnership with the federal government predominantly, as well as the provincial governments.

The unique setting creates many challenges in providing services and programs, because we have to work—specifically around today's presentation—within the health requirements of two provinces, but yet one community. In addition, our community of Akwasasne is geographically landlocked by the St. Lawrence River, separated from the Canada mainland, as well as the United States. The three districts which the Mohawk Council services—Cornwall Island, Tsi Snaihne, as well as Kanatakon, which is also known as St. Regis village in Tsi Snaihne—are all under the jurisdiction of the Mohawk Council of Akwasasne.

We also have the added burden of having to report to the CBSA, which is located in the city of Cornwall, before returning to the district of Kawehnoke, which is Cornwall Island in the province of Ontario. This port of entry is the tenth busiest, with approximately two million vehicles crossing annually, with 70% of the traffic being Mohawks of Akwasasne. I reiterate that: 70%. When we look at border-crossing communities across the nation, there is no other community that has 70% of the traffic crossing the border daily, and 70% of that traffic being indigenous peoples. There's a huge difference here, when we talk about border communities and people trafficking all the time. Nowhere else in this country will you find the same people crossing predominantly across that international border all day, every day.

Despite this, the MCA has diligently worked to minimize the impacts of the border on the daily lives of our community by negotiating special arrangements for areas like emergency services. We also utilize a political protocol with Canada, to call Canada and the provinces to a table to discuss solutions to jurisdictional challenges that our community faces. This also includes the health care area.

Akwasasne delivers indigenous services similar to what other first nations communities offer. I must highlight that for the past 20 years we have run our own ambulance services funded by Ontario, Quebec, and ourselves, delivering ambulance services to our community. For the past 22 years, we have been in full control of our Akwasasne non-insured health benefits program, which is normally administered now by Indigenous Services, but formerly by Health Canada. For the past 25 years, we have operated Tsiionkwanonhso:te, a 50-bed long-term care facility licensed and supported by the Ontario Ministry of Health. For the past 23 years, we have operated Iakhihsohtha, a 30-bed care facility in Akwasasne within the Quebec district. We operate four medical clinics across Akwasasne. We operate a fully functional traditional medicine program, and we provide a 30-day rural health work placement for medical students from McGill and Ottawa universities, which incorporates work with our traditional healers.

● (1640)

One of the things that we heavily promote is our partnerships with the federal government, municipal governments, private businesses, and institutions such as colleges and our universities.

The entire Mohawk Council of Akwesasne Department of Health is accredited under the auspices of Accreditation Canada, meeting the highest Canadian quality standards of health services. This is something we're extremely proud of.

In short, our services have evolved into a truly integrated health system, using our culture and values to guide western health-related sciences in program delivery. This is done through exclusive use of our traditional language, traditional medicine, and traditional ceremonies.

I'll now turn it over to our director of health, Keith, to go over a bit more of the programming that we deliver.

Mr. Keith Leclaire (Director of Health, Mohawk Council of Akwesasne): *[Witness speaks in Mohawk]*

I'm very proud to be here, and I'd like to share with you our long-term care concerns.

First of all, from Akwesasne's perspective, we understand fully well that the Canadian health care system is fragmented—some provincial stuff, some federal stuff. However, it is our responsibility in Akwesasne to make sense of the different multi-jurisdictional issues, to find solutions, and to meet with the appropriate entities to make that a reality.

Indigenous Services provides support at the federal level, with Ontario health and the réseau de la santé Québec offering support at their levels. Almost half of our community is served with OHIP for insured services, and the other half is served with RAMQ for insured services from the Quebec side.

I think you have had a good chance to see what's on the map over there. Short and sweet, we have roughly 12,500, as Grand Chief Benedict has said. We're pretty well split up, with about a 45-55 split between the Ontario and Quebec groups.

However these multi-jurisdictional issues for Akwesasne have created challenges in providing seamless secondary and tertiary health services. When we provide outside of Akwesasne, Ontario, we have to come up to Cornwall, and we have to go in for tertiary services to Ontario, basically Ottawa. On the Quebec side, we have to go to a smaller community, Barrie Hospital, which is located in Ormstown, Quebec, about 45 minutes away, and for tertiary services, we have to go to Montreal. These are samples of where we are.

As is normal, we face these jurisdictional challenges daily. We search for solutions, using innovative approaches and partnerships to resolve the jurisdictional issues we face.

Long-term solutions require a community, strength-based approach, and basically we're doing that. Our community has strengths that afford prioritizing our services to meet the needs of our community members. Our strength is in our ability to prioritize those services. In addition to our community approaches, we offer you a portrait of opportunities within the current system that we hope you will be able to listen to and give some thought to some of our reflections.

The first point we want to tie in is on infrastructure. Akwesasne recommends that you examine the support for maintaining existing resources that are now under community control. This hasn't been considered very well up to now. Akwesasne's long-term care facility is Tsiionkwanonhso:te, and in medical terms that's a level 4 care service. Tsiionkwanonhso:te, by the way, means "our house" in our language, and that's just what it is. It's not an institution; it's an extended part of our community.

Our level 1 and 2 care service is Iakhihsohtha, which means "the home of our grandparents". We've operated both of these, as Chief Benedict has said, for more than 20 years. Our concern right now is that these two care facilities require infrastructure improvements and support to continue providing the quality services that we give.

Right now, I think long-term care requires long-term support for infrastructure, given the fact that our long-term care facility is actually funded by the province, yet it is located in a first nation territory under federal government jurisdiction.

Due to the federal-provincial divisions of authority, we require your support to seek solutions as we talk about more large capital investments. If we want to continue providing long-term quality care for our people, we need to make sure we have the infrastructure and the buildings that are sufficient to meet the codes.

We are unable to access capital and infrastructure enhancements right now, and I think that's a point we want to make sure you consider in the writing of your report. Please look at this as an issue.

Also, what we're looking at now is prevention. One of the things that our health services, like all of those across Canada, needs to focus on more is the preventative aspects of long-term care.

I think most of the time we're here talking about what the needs are for the facilities, but I'd like your assistance in recommending some departmental support to assist in capturing evidence-based data to show our success, especially in prevention support activities.

● (1645)

I've asked a number of times, and the reply I keep getting back is that it's a bit too complicated. You can get back information on an annual basis about how many people came to a facility, how many people are there, but, in fact, when we start talking about prevention, that isn't done over a three-year or a five-year period. It's done over 10 years, or over decades. One weakness in the system here is that we have to look at how we can support the challenge to get better evidence-based information on this.

What I'm really tying in here is that a prevention type of evaluation is longitudinal in nature and it takes time. As we know, Canada is facing an aging population overall, and we all need to be innovative. I think that's one of the areas we should be looking at, looking outside the box.

Also, Akwesasne has better services provision than do most other first nations across Canada, and we offer you this advice: There will be gaps in service levels in the long term.

Right now your definition under the federal classification system for institutional care, which is found within the National Assisted Living Program Guidelines 2018-2019, delineates service responsibility between Health Canada, FNIHB, and the previous DIAND under the assisted living program. Right now, I expect modifications of this classification system, with greater community-based participation, and, in fact, we at Akwesasne are prepared to assist you with any technical revisions to make sure that does happen.

Our biggest concern also is for the mental health and mental wellness of our elders. There needs to be consideration to enhancing programs that impact mental wellness for our elders given our size and districts in Akwesasne. As you can see, we're spread out. The reality is that it is difficult for long-term care clients to socialize.

The last point we are really trying to tie in here is that we have to ensure there is an acknowledgement of volunteerism. Most of the time a lot of our activities that are going on are adult care, day care services, and meals on wheels, and a lot of times we have a lot of individuals who are providing mental health support. In reality, what we need to do is to make sure we have recognition through your recommendations to support and enhance volunteerism at our community level.

With that in mind, I'll pass it back to Chief Benedict.

● (1650)

The Chair: I think we have run out of time for this presentation, but we will dive into it with questions and we—

Mr. Mike Bossio: Why don't we let the chief finish, Chair, if you don't mind. He has just one quick comment.

Grand Chief Abram Benedict: Very quickly, I just want to wrap up what the director has said. I just want to reiterate that jointly Akwesasne, as one of the few communities that have beds existing now, has a vested interest in the work you are doing. With what we have said today, with the service delivery model we have, which we have delivered for a long time, I think we can partner together and learn from our challenges and learn from our successes. We are a large progressive community that is in a very unique situation, in that we are spread over an international line, and we deliver culturally appropriate services in the provinces of Quebec and Ontario. Our organization is made up predominantly of our own people who deliver these services daily to meet the needs of our community, and I know that we have very similar goals in mind here.

We are here to bring a message to you that we're prepared to work with you to develop your report, to make recommendations, to see that we ensure that we are meeting the needs of all first nations and Canadians across this country.

In closing, I do invite all of you, as I have in the past, to visit our community, which is about one hour south of here. Don't forget to bring your status card or passport.

Thank you.

The Chair: That's a valid status card.

The questioning moves first to MP Will Amos.

Mr. William Amos (Pontiac, Lib.): Thank you, Grand Chief and Mr. Leclaire. We really appreciate this testimony. It's eye-opening and really does help us to understand an alternate reality that the vast majority of Canadians don't experience.

I really just want to give you more of an opportunity to talk about the long term, not just about what needs to happen in the next year, three years, or five years. Where do you see long-term health care, and health care more broadly writ, for the Akwesasne community in 10, 20, 30, or 40 years? How does that evolve? What is the vision?

Grand Chief Abram Benedict: I think that as we know, in all populations statistically, the population continues to grow whether it be indigenous or non-indigenous. As Chief Maracle testified earlier, housing is a huge component to our communities, including our own. From a service delivery perspective, we outlined that the capital needs are huge as well because the facilities we maintain and operate also have aged and continue to age. We need to be able to meet that need and continue to deliver a service that's expected of us, that's required of us, and that our community expects.

As the government starts looking at ways to transform contribution agreements, looking into flexibility, this also applies to the health care sector as well, because sometimes we end up reporting on things that are probably not all that useful anymore.

We talked about data. Our organization is very large, with eight departments and $100 million in services, but it's sometimes difficult to collect all that data together. It's an engine, though, that does exist to be able to do that. I'm looking at supports. I know other communities have them as well. As we look to grow as an organization, we look at innovative ways to be able to pull that data together, to be able to innovate our services, meeting our accountability and transparency requirements of our funding partners as well as our community—which is absolutely important to us—but also having the flexibility that we need in these long-term agreements as well, for sustainability.

Those are some of the high-level concerns. We know that our community continues to press upon us to provide seniors housing as well as facilities, long-term care facilities, whether it be chronic, acute, or just simply living facilities. As we continue to grow as a community, we continue to plan for this. I'll look to add a bit more on the program delivery side, but that really is the high level of where we're going, our vision, as a community and as a service provider to our people as well.

● (1655)

Mr. Keith Leclaire: I'd like to also share too, Mr. Amos, that one of the things we look at is culture as the foundation of our health development. For long-term care, we believe in capacity building, having our own members to be able to carry on that activity.

Normally one of the things that we find is that most people don't understand that when we're speaking our own language to give an explanation about what diabetes is. You cannot do that unless you have a thorough understanding from a medical perspective. The definition for diabetes is "you have sweet blood". That implies something positive. We have to keep on looking at these things. We have to be relevant. The bulk of our elders still speak our language, and we have to make sure that we can accommodate them to understand some of these realities.

The other thing that we're looking at too is the wisdom of how we can pull out additional access resourcing, especially through knowledge. The enhancement of our health programs is going to be done three ways: with improving our knowledge, with improving our skills, and with improving our attitude on how we give service to our community members. A lot of the times, we get mixed up with the numbers. However, the reality for long-term care is that we have to remember that those people who are coming in are in *tsiionkwanonhso:te*. They're in our home. They're *akhsó'tha*. They're our grandparents. That's the connection. I can tell you right now, the bulk of our staff are first nations, and the majority, 90% of them, are from the community of Akwesasne.

I hope that answers your question, Mr. Amos.

Mr. William Amos: That's very helpful, thank you.

What role do you see for traditional knowledge in the development of long-term health care planning in your community?

Mr. Keith Leclaire: Traditional medicine and traditional healing approaches are more extensive, and you get more value out of those than you do if you were to look at simply a dollar sign. The reality is that we need to socialize and make sure there's stimulation of our elders to ensure that they can stay home. Our goal is to keep our elders at home, and we're doing that. The issue that comes up, though, is when the time comes when they require more care.

The reality comes out. How do we do it? They go to these facilities that are in our community, are very community friendly, and use the same language. Most of the people in there are people you've grown up with, you've lived with your entire life. It's an extended family component. That's a priority of what we have to do in other first nations, to keep this going.

The Chair: Thank you.

The questioning now moves to MP Kevin Waugh.

Mr. Kevin Waugh (Saskatoon—Grasswood, CPC): Welcome. I want to thank you, Grand Chief Benedict, for your presentation. It was very good. And you too, Mr. Leclaire.

This is an interesting topic, this long-term care on reserve, because when we go off reserve—and I have a number in my city of Saskatoon—all we get now is foundations. They are out of money. The provincial government isn't giving them any more so now we have a pyramid of foundations. They're always fundraising. What do you do?

There are eight facilities in my riding alone. Everyone has a foundation. Everyone is raising money. The provincial government is giving them less, and they have to go out and raise money.

How do you raise money? Do you have foundations? Do you have pyramids where you can go out and partner and all that?

Grand Chief Abram Benedict: On occasion we do hold bake sales and things like that, but they don't amount to very much, maybe the fuel for the bus to go to the park or something.

Mr. Kevin Waugh: You know where I'm coming from here, though.

Grand Chief Abram Benedict: One of the things we're fortunate to have.... The Mohawk Council is a delivery agent for a number of services in partnership with the federal and provincial governments. We deliver a lot of programming. The long-term care facilities are facilities for our elders, and they are a huge priority to our community. They are our elders. That's where we began. They are the knowledge keepers. They are the language keepers. We have the ability to be able to support the facilities a bit more than if they were stand-alone facilities.

By integrating some of the services that may come into the facility, whether it be though another partnership with Health Canada or a partnership through the province, we are able to support one another through a holistic approach.

Not all communities have the ability to do that. There are shortcomings. By far the capital is one of the areas we face a challenge with. Is our facility generating profit? Absolutely not. Is it supposed to be? No. Is it breaking even from the contributions? No. Is it because it's a priority, and we have the ability to finance it other ways? Yes. We're able to do that.

That's how our community can, but for facilities that are stand-alone, it's very challenging. It comes down to community priorities. If a council is running a long-term care facility, and it's between shutting the doors in a long-term care facility or providing new homes, sometimes it goes into continuing the facility to operate.

● (1700)

Mr. Kevin Waugh: I would think you're way above the national average. I've counted over 100 beds you have, including one facility that was built in 1990, which is 20 beds. Now you have gone from set funding to block funding. What's the difference?

Grand Chief Abram Benedict: I think it's the flexibility that exists within that, but, again, to my earlier comments, it's only flexible to a certain amount. I know the federal government is looking at grant-like contributions for longer periods of time. Those sorts of initiatives will give the community a better ability to plan longer term and to be able to prioritize longer term.

Block funding has assisted to a certain degree, but it's not the answer to keeping the fundraising from happening.

Mr. Kevin Waugh: Mr. Leclaire, you have talked about culture, about foundation, which is very important. We are looking at long-term care on reserve. In my province, we always want to ship them out of their community. We have the first plane on the runway, to bring them to Saskatoon or Prince Albert. That's probably not the right answer, but that's what's happening in our province right now. It's a different culture. I don't think we're there yet in my province.

How do you do it? You're working with Quebec. You're working with Ontario. You have the border.

Mr. Keith Leclaire: We believe in partnerships. If we have an issue, we are going to identify that issue. We're going to find out the trigger; why is this problem arising? Then we're going to look at the basis: what causes it?

You gave a good example when you described that everybody in Saskatoon was asking for money and they have all these foundations. If I were in your shoes my question to them would be: what do you need the money for? Because you have so many small groups, maybe there is a need to do what we have done in Akwesasne—come together and prioritize the need, and then work on that.

I'm very proud to say that we run ambulances, and the reality is that when we needed a new ambulance, our community came through and provided over $200,000 to be able to purchase a new one and to give the best cardiac monitoring machines to go into each one.

We can sit down as a group, and we can haggle. Sometimes it's longer than days, but once we come up with the priority, we come with one mind.

When I talk about a cultural perspective, as the Mohawks of the Gayanashagowa, we believe we're following what's known as the Great Law of Peace, which indicates there are five main tenets that we have to follow in our daily lives. One is peace: we have to be at peace with ourselves and at peace with others; we have to have respect: respect for ourselves and respect for others; *kanikonriio*, which means we have to be of good mind and we have to come together because we know we can't solve it, and if we can't, we're going to get stuck, and we're going to be in our own areas; the fourth tenet is being responsible: we know our responsibility and how the other people we're working with have to be responsible; and accountability: every government has it and that is one of our main tenets as well.

Mr. Kevin Waugh: We just heard about this ambulance. How much does it cost your reserve to use the ambulance? That is an issue on every other reserve in this country.

● (1705)

Mr. Keith Leclaire: Every province provides funding in a different manner. If you're on the Quebec side the charge is a $125 flat rate to leave, and it's $1.85 or $1.90 per kilometre to get to the closest health facility.

The Chair: Sorry, we've run out of time, Kevin.

Mr. Kevin Waugh: That would have been a great answer.

The Chair: Let's conclude with the great answer, and then we'll move on. I don't want to shortchange Rachel.

Do you want to complete?

Mr. Keith Leclaire: Maybe I can just follow with the ambulance. The most important thing I want the committee to know is that last year we had 156 ambulance calls in our community, and 48% of them were for elders 65 and over.

I challenge everybody here to ask those ambulances that service the communities of other first nations, what is that level? I think one of the things is that we're talking here from a federal perspective, but we don't have the information from the provinces because all of them are provincially run.

I challenge Mr. Waugh to take a look at that.

Thank you, Madam Chair.

The Chair: MP Rachel Blaney is next.

Ms. Rachel Blaney: Thank you so much for being here with us today. I appreciate your presentations and the information you're sharing.

One of the things you both talked about was the preventative method, and that we need to be looking at how we're going to see more prevention. It came back to that part of how we have that support to collect data.

I represent over 20 very small indigenous communities, and that is a huge challenge. Anecdotally they can tell you a lot of stories, but meaningful data collection is just not there.

I'm wondering if you could tell me a little about why you feel they said it was too complicated, and whether you have any thoughts on what data we need to collect.

Mr. Keith Leclaire: Most of the time if you speak to an epidemiologist and people who are looking from a research perspective, research dollars are usually very generalized in the number of years they can do it.

The last time anything was done specifically on diabetes for first nations, I think it was done under the old national health research and development program in the early eighties when there was a five-year study. Every other one since then has only covered two or three years. I think the bottom line that comes out of it is, where do we go forward?

We need to ask what the indicators are for prevention to succeed. Most of the time, the indicators we're collecting now are more financially related so we can share with the government, obviously through Treasury Board. At the provincial level it's the same thing.

Maybe we need to think outside the box, and look at a way that it can be done so it can be much clearer. That's the point we're looking at right now.

I'll go with another good example. If we look at home care and home care services, what are the indicators? The indicators are: how many people they went to; how many people they saw; and how many times they went to see them. My only concern is, what are they going there for; what is the issue; and what is the general state of health of that individual elder? That's not really accommodated because we're more fiscally accountable than we are to the best case management of the individual's health.

Ms. Rachel Blaney: Thank you.

The other thing I have a question about is caregiver burn-out. I'm just wondering about the challenges that you face with respect to people who do caregiving. We heard stories from the last witnesses, and this is a growing concern, so I'm just wondering if you could share a little bit about that.

Mr. Keith Leclaire: One of the very fortunate things about our community is that of our five physicians, two are first nations and they understand the language. They do home visits as well, along with our home care nurses.

We need to do this: if there is a problem and they're starting to burn out, we will pull them into our elders lodge. We know that's an excess burden on our staff, but we feel it's important. We can bring them in for either the weekend or a short period of time, upon the approval of the physician, and we ensure that we have the staff to take care of them.

Bear in mind that when it comes to respite, we're bringing somebody in who's already being followed by the home care nurses and a physician, and it's on the physician's recommendation. It's not for the individual care of the elders; it's for the individual care of the caregivers, the family members. That needs to be looked at more because, again, we're too focused on.... We have to think outside the box, and that's what we do in Akwesasne.

● (1710)

Ms. Rachel Blaney: Thank you.

You talked about the need to change the definition of "assisted living", that it needs clarification. Can you just tell us a little bit about what that means?

Mr. Keith Leclaire: Under the national assisted living guidelines, five levels of care were identified by the federal government back in 1983. Those indicate that type I care is the support of nursing care for under 90 minutes a day. Type II is for under two and a half hours per day. At type III, it jumps up to about five hours. At type IV, it goes to full-time requirements, and type V would be for those who require nursing care 100% of the time.

We need to look more at this because we've been provided a type I or type II facility, but we're giving the care of a type IV facility. With regard to type III, in today's world, we're actually talking about chronic care, and there's nothing in that system.... Bear in mind, when assisted living came through, departments were apart, and I recommend to the committee that it look at re-evaluating them.

Every province and territory has a different definition of levels of care. Some have four, and some have six. The reality is that you can't match them. We're faced with a multi-jurisdictional issue. There is a big difference between Ontario and Quebec with regard to levels of care.

The hardest thing for us is evident in that little map that you see over there. On the right-hand side is a white part, which is Quebec, and a couple of people from our community live there. However, we cannot service them simply because our qualified nurses are mostly from Ontario and are only given a special privilege to work in our community. In fact, there are a lot these standing orders. We've been very grateful that Ontario and Quebec have provided us with the opportunity to get special licences just to work in our communities, but sometimes that impacts the quality of care because we can't reach out to people. Because there's no housing there, we can't go out and service them. We have to send them through the Quebec CLSC network, and we have to make the arrangements with that.

Ms. Rachel Blaney: That's amazing.

Grand Chief Benedict, one of the closing comments that you made was about how we share the expertise that we've gathered. As a person who represents very small communities—and you represent a very large one—there is a challenge, and people don't know what's out there.

Do you have any ideas about how to share those best practices?

Grand Chief Abram Benedict: In our community, we have a very strong governance system, and I attribute that to a lot of the service delivery models, institutions, and partnerships that we have. I know that enough communities struggle with this. We have been telling indigenous services that as they look at transforming the way they fund communities, we are prepared to work with them to also provide support services for governance as well because through the health services we deliver, there's a strong support system around the institution that supports them. It's a very holistic approach.

To a large extent, our organization delivers programs under Jordan's principle, and has for a really long time. When you look at that map and consider some of the examples that Keith described, keep in mind that we cannot compromise safety and well-being based on where a person lives, and we cannot deliver two tiers of service based on where a person lives. It becomes our responsibility, as the Mohawk Council and as leadership, to find a way to deliver that service seamlessly. There's a lot of backroom work that happens in administration, politically, and from the governance level. That's what we offer to the government so that we can learn from one another and support other communities because indigenous communities helping indigenous communities is what we need.

The Chair: MP Danny Vandal.

Mr. Dan Vandal (Saint Boniface—Saint Vital, Lib.): Thank you very much for your very interesting presentation.

I just want to continue on the jurisdictional issue. You've highlighted, or you've mentioned, some of the issues going from Ontario to Quebec—actually, the nurses cannot go to Quebec—but are there any jurisdictional issues with the American side? I'm assuming that some of your reserve members live in the United States. What issues does that bring up?

● (1715)

Mr. Keith Leclaire: Most of the time, if there are services that are provided, we have to work on agreements with the American side. Our ambulance services have the capacity—and we have served in the past—to support the services provided on the American side. All of our staff are certified in both New York state and Canada, so we won't have any difficulties.

Again, the complexity, as Chief Benedict highlights, is when we have to bring somebody from one part of our country into Cornwall. The bottom line, again, becomes the issue of customs. It's the question of bringing it in, even on emergency. Up until now we've had a department of health for the American side, under the Indian Health Service. Weekly, I'm in a meeting with the person there to identify.... I've had good discussions with the director, Mr. Cooke, who is my equivalent. Our executive directors have spoken on many occasions, and so have our chiefs.

The question is how to give the best quality of service to our clients, but the bulk of our services and activities... I believe that just on ambulance calls alone, roughly 79% were on the Canadian side. The remainder were on the American side, but that's part of our mutual agreement.

Mr. Dan Vandal: Your population, I believe, is 12,000.

Mr. Keith Leclaire: Yes, 12,500.

Mr. Dan Vandal: Does that include the American side?

Mr. Keith Leclaire: No. In the United States, they are covered under their own tribal system, so in fact they have their own governance system, whereas Chief Benedict is responsible for the entire Canadian portion. There is a separate portion.

Chief Benedict?

Grand Chief Abram Benedict: I think that sometimes we are challenged by our contribution agreements, which have stipulations for various things. We do work very hard with our partners at the Saint Regis Mohawk Tribe to find areas that we can work together on, but the end of the day, sometimes we're bound by the agreements we have with the government.

Mr. Dan Vandal: Okay.

In terms of demographics, do you anticipate, based on the demographic research that you've done, that there will be a wave of older citizens who are going to need long-term care in the future? How is that looking for your reserve?

Mr. Keith Leclaire: What we see right now is that this is going to be the trend. I don't think it's going to be as fast as the Canadian system, but the reality is that we've been very fortunate multi-jurisdictionally. We're hoping to develop something sort of like what we have with our public health. We have an agreement between the Government of Quebec and the Government of Ontario that administer that component, and there's actually cost-sharing, with Quebec giving to Ontario, to provide that. Immunizations and any outbreaks in any of our facilities are handled by those components. We have to keep on looking at who our partners are and how we can make it better so that we're serving the community. We're definitely not shy about starting up memorandums of agreement or finding ways to improve the service.

Mr. Dan Vandal: You mentioned earlier difficulty in collecting data. I believe you said that when you asked—I assume it was the Canadian government—the person said it was too complicated. Do you have a general idea of what elements or variables you'd like data on?

Mr. Keith Leclaire: What I'd like to do is look at the indicators of the major issues in dealing with our elders. With the ambulance, where we do have a good system of components, the bulk of our elders are dealing with two major issues: respiratory and abdominal pain. If you think about these two components, do you know what they're caused by? Mental wellness and stress: "Who's going to come visit me? Who's going to help me get stuff?" These are the issues, and nobody's concentrating on them or looking at them. I think we're fortunate that we have the information and the data, but we're so small. I'd love it if you could recommend that the rest of Canada really start asking, "What are the indicators that make people well?" That I would very much appreciate, Mr. Vandal.

Mr. Dan Vandal: Okay. Good.

On home care, according to my briefing note, you have in-home nursing care—an entire home care program.

Mr. Keith Leclaire: Yes, we do.

Mr. Dan Vandal: Can you tell me a little about that?

Mr. Keith Leclaire: It's one of our nine programs within the department of health. We include not only the nursing care; we also provide the service for at-home care. In fact, we have an interesting challenge because of the distance. To go from the left-hand side of the area, where you have Cornwall, to the farther tip of Snye, which is on the far right, that's roughly a 35- to 40-minute jaunt.

When we send out our nurses, we usually have to identify who's going to be covering off in what district. The bottom line is that we have limited resources. Financially, we can locate additional people to provide the services, but we're going to manage with what we have. We're going to be able to provide the best service we can, but we definitely are looking at how we can do a good analysis to be able to show those activities that are being done.

If you look at the home care results right now, what are we talking about? How many people are there? What is the percentage of time per person? Those are good, but it doesn't give any indication of what the major issues are. Are there problems right now with potable water? Are there problems with rats and rodents? What exactly is the leading cause of the diseases? Those are the things that I would like to see worked on, and I recommend that this be considered when you develop your proposal.

Thank you, Mr. Vandal.

● (1720)

Mr. Dan Vandal: Thank you.

The Chair: The questioning now moves to MP Cathy McLeod.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): First of all, thank you for a very informative presentation.

As I look at that map, I think of how it would be easier just to move the lines than to deal with what you have to deal with every day. I just can't imagine those jurisdictional challenges that you've faced for a long time. I also really welcome your invitation. Hopefully, either our committee or even some of us individually can come out at some point and have a look at what you're doing out there.

Here's the first area that I was wondering about. We've come to this data issue a few times. I can remember that in British Columbia the care cards had some identification, so for first nations there was the ability to collect data related to care cards. Then there was a really big concern amongst first nations in terms of the government collecting data.

How do you do that respectfully? I hear your interest in having data in terms of what you do, how you do it, and how you deliver it, but I'm not sure that you want the government doing that. Has there been any work around the development of some kind of first nations institute for data collection? I know that it was a very sensitive issue in British Columbia. Are there any comments on that particular area?

Mr. Keith Leclaire: I'd be more than happy to share with you, Mrs. McLeod, that one of the things we believe in for first nations to function is the concept that for any data, the ownership, the control, the access, and the possession should remain with the first nation.

The bottom line that really comes out is that is if somebody is collecting it, a protocol should be prepared and identified. If you're giving a person the responsibility of carrying out information gathering, right now what we expect is a clear delineation of what it's going to be used for, what's going to be the result, how the community will be involved in the analysis, and how the community will be involved in the dissemination of that information.

Once that's over, we expect them to ensure that all of that information collected by outside researchers is totally returned and the property remains within the community. Part of the agreement we sign, if we have somebody on the outside coming in to do it, is that they have to give all of the data back to us so that it's safe, and they are to delete anything that's in their records.

Mrs. Cathy McLeod: If it's not related to research and more for your planning purposes, do you see it being done at your council level or by a broader group of first nations coming together? Can you drill down a bit? Have you done anything on that?

Grand Chief Abram Benedict: In response to that, one of the challenges we face with respect to data as a whole is the infrastructure and the financial support to put those systems together. We always have competing interests for all kinds of infrastructure, whether it be IT infrastructure, roofs over the long-term care facility, or financial infrastructure. We struggle daily with this in trying to balance all of that.

The challenge in introducing a data system that may integrate all of our organizations—we have eight departments within the Mohawk Council of Akwesasne—is instituting that infrastructure. It's the cost to institute that infrastructure, as well as the training components and the maintenance components, right? That really would be a huge bulk of a challenge to get over.

Of course, as you know, when we're all identifying priorities in budgets, are we going to create more beds or are we going to put some data infrastructure in...? That's what it comes down to at the end of the day. Although there's an understanding that data is extremely important for planning purposes, reporting purposes, and transparency purposes, for us that's what it always comes down to.

● (1725)

Mrs. Cathy McLeod: CIHI does some pretty good data collection. Has there ever been thinking about that partnership with CIHI?

Grand Chief Abram Benedict: We have partnered in the past with other institutions for some data collection in specific areas, of course, respecting all of the principles that Keith has outlined. It is a possibility, but again, I think it comes back down to the infrastructure investments and maintenance of being able to do that.

Mrs. Cathy McLeod: Do you have an electronic health records system within your community and does it talk to the outside, both Ontario and Quebec, facilities or do you have medical summaries that move back and forth?

Mr. Keith Leclaire: I'm happy to say that we've just entered into an agreement with Connecting Ontario to be able to start the development of EMR directly with our groups.

The town of Cornwall is right next to us and the major hospital that provides that service is not yet with Connecting Ontario. In fact, we can get our services from the tertiary services out of Ottawa, Ottawa Hospital and CHEO. We have no problem, we can get that back directly now.

The problem though is that this is a new process, so we're at the beginning stages and I think we do hope that we can get that taken care of. That's just for the Cornwall Island side. We still have to do our negotiations with Quebec for the Quebec side. Again, there are different nuances and different peculiarities in both provinces.

The Chair: It's very complicated because these borders are just so artificial compared to the history of your nation.

Mr. Mike Bossio: I had just one quick question.

You have a 30-bed and a 50-bed facility right now on the territory.

How many people do they employ?

Mr. Keith Leclaire: The total amount for the long-term care facility of 50 beds is roughly 70 to 75, depending on the resourcing we can get. The other one is roughly half that size, about 30 to 35.

Again, the majority of our people are all from our communities and especially for Iakhihsohtha, the elders lodge, we try to ensure that the people who are working there are fluent in our language.

Mr. Mike Bossio: So they're very good, long-term, well-paying jobs.

Mr. Keith Leclaire: Put it this way, we would love for you to come and see, Mr. Bossio, and I think you would be able to get the reaction—not from me or Chief Benedict—but from the staff who work there.

Mr. Mike Bossio: As well, what's good about this is that the more we can satisfy this need and other similar needs in the health care realm, the more good jobs we can create to help create that sustainability within the communities themselves.

Akwesasne, like the Mohawks of the Bay of Quinte, are more in the south so there is spillover that they can work on and off reserve. But in other more remote places, these can provide the employment that so many desperately need in our communities.

Mr. Keith Leclaire: Yes, Mr. Bossio.

I think the important thing too is, I do want to highlight, that one of the strengths we have is the wisdom of our leadership. The leadership have asked me to come to work here. I was working in a northern community, the isolated northern community of Kawawachikamach in northern Quebec, when the council asked me to come in to be interviewed.

The one thing that I'm bringing with me is the wisdom of what I've seen. I was around first nations health in 1980 when Monique Bégin was here. I remember the 1979 Indian health policy. When you're talking about the smaller communities, you can apply the concepts of what we're using here in Akwesasne, provided you can get concurrence at a tribal council level because then you would amass the same population levels. You would also amass probably the same types of services. Again, that has to be negotiated among the first nations in the smaller groups, but that opportunity is there and we'd be willing to share our wisdom of what we have here.

● (1730)

Mr. Mike Bossio: I really wish I'd had the time because the main question I'd wanted to ask was around this. You're leading the way somewhat in providing these services, and that example that could be provided to those communities that want to get into those services. I would really like to see if you could submit a brief that would maybe cover off some of that aspect of it, so that we can consider it as part of the report.

Thank you so much.

The Chair: Thank you for coming.

The meeting is adjourned.

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